Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST LUKES EPISCOPAL HOSPITAL
6519 FANNIN ST
HOUSTON TX 77030-2703

Respondent Name

SERVICE LLOYDS INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-98-5495-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pursuant to instructions in TWCC Advisory 98-1, attached is additional evidence supplied by St. Luke's Episcopal Hospital which supports our position that charges submitted on workers compensation claims are reasonable and necessary under TWCC Rule 413.011(b)."

Amount in Dispute: $946.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier received a request for a re-audit of the bill in question in June 1997. The bill was then re-audited by Forte' who recommended no additional payment. Copies of the subsequent audit, and payment if applicable, were forward to the provider, and copies of the same are attached."

Response Submitted by: Service Lloyds Insurance Company, PO Box 26850, Austin, Texas 78755-0850

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 1996 to December 17, 1996	Inpatient Hospital Services	$946.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 2, 1997.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Payment based on the Assigned Per Diem Amount per the Texas hospital fee schedule.
   - G – Payment for these series is included in the Per Diem amount.
   - F – The amount charged exceeds the maximum allowable fee for the Texas Workers' compensation Medical Fee Guideline.
   - M – Payment reduced according to fair and reasonable.
   - M – The amount paid is equal to or exceeds the payment required under Texas Workers' Compensation Act (TWCA) statutory standard for payment of medical providers.
   - S – Previously recommended amount has not been changed.

Findings

1. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
2. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
3. Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Pursuant to instructions in TWCC Advisory 98-1, attached is additional evidence supplied by St. Luke's Episcopal Hospital which supports our position that charges submitted on workers compensation claims are reasonable and necessary under TWCC Rule 413.011(b)."
   - Review of the submitted document finds that the data does not support the reimbursement amount sought by the requestor.
   - Regardless of whether the hospital billed its usual and customary charges or whether the charges were comparable to charges billed by other hospitals for similar services, no documentation was found to support that the amount charged for the disputed services represents a fair and reasonable reimbursement for the services in dispute.
   - In numbered paragraph 4 of St. Luke's Response to TWCC Advisory 98-01, the requestor asserts "The request for reimbursement does not provide for payment of a fee in excess of the fee charged for similar treatment of an individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. Yet in numbered paragraph 1, the requester states, in pertinent part, that "St. Luke's discount rates for workers' compensation and managed care contracts are as follows:...

Workers' Compensation...		Managed Care Contracts...	
1996	47.8%	1996	41.6%
1997	50%	1997	45.3%"

   - The requestor is seeking reimbursement at 100% of the billed charges for the services in dispute. Given that the requestor states that it discounted it's other workers' compensation and managed care contracts services by 47.8% and 41.6% respectively during 1996, the same year that the disputed services were performed, the Division finds that the requestor has not supported its assertion that the request for reimbursement does not provide for payment of a fee in excess of the fee charged for similar treatment of

an individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.

- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	December 22, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.